Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SPINE HOSPITAL OF SOUTH TEXAS
18600 N HARDY OAK BLVD
SAN ANTONIO TX 78258

Respondent Name
TPS JOINT SELF INS FUNDS

Carrier's Austin Representative Box
Box Number 11

MFDR Tracking Number
M4-05-0900-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary:. The requestor did not submit a position statement for consideration.

Amount in Dispute: $15,654.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's surgery report attempts to cast the surgery as emergent, yet its cursory attempt falls short of satisfying the statutory standard. Nowhere is a 'sudden onset' of anything other than episodes of urinary incontinence documented. True, the Provider lists a number of symptoms which allegedly necessitate emergency surgery, but the Provider fails to document how the absence of this surgery could be expected to result in serious jeopardy to the Claimant's condition. Simply because the Provider says the surgery was emergent does not make it so."

Response Submitted by: Harris & Harris; Attorneys at Law; 5300 Bee Caves Road; Austin TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2003	Outpatient Surgery	$15,654.89	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, provides for fair and

reasonable reimbursement of health care in the absence of an applicable fee guideline.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. 28 Texas Administrative Code §134.600 effective January 1, 2003 sets out the requirements for preauthorization.
5. 28 Texas Administrative Code §133.1 effective July 15, 2000 defines a medical emergency.
6. 28 Texas Administrative Code §401(a)(5) requires that emergency services not leading to an inpatient admission are not covered by this guideline and shall be reimbursed at a fair and reasonable rate.
7. This request for medical fee dispute resolution was received by the Division on October 5, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 8, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - A – preauthorization not obtained per adjuster
   - O – denial after reconsideration (per adjuster-preauthorization was never obtrained)

Findings

1. The respondent denied disputed services with reason code A – "preauthorization not obtained per adjuster". On the Table of Disputed Services, the requestor states "the treatment/service denied via payment exception code 'A' by the Carrier is not referenced in 134.600 (h) and the healthcare provider was not required to procure pre-authorization for the treatment/services in question..." 28 Texas Administrative Code §134.600(b), effective January 1, 2003, 27 *Texas Register* 12359; states that "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury: (1) listed in subsection (h) or (i) of this section, only when the following situations occur: (A) an emergency, as defined in §133.1 of this title (relating to Definitions); (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care." §134.600(h) states "The non-emergency health care requiring preauthorization includes... (2) Outpatient surgical or ambulatory surgical services..." Review of the submitted documentation finds that the disputed services are outpatient surgical services as listed in §134.600(h).
2. 28 Texas Administrative Code §133.1(a)(7)(A), effective July 15, 2000, 25 *Texas Register* 2115; defines a medical emergency as consisting of "the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health and/or bodily functions in serious jeopardy, and/or serious dysfunction of any body organ or part." The requestor's Outpatient History/Physical Exam Operative Report dated [redacted] states [redacted] The Operative Procedure note states "INDICATIONS FOR SURGERY: patient...with [redacted] The Operative Procedure note further states "PROCEDURE IN DETAIL... [redacted] The Division finds that the requestor has supported the existence of a medical emergency. Having demonstrated a case of emergency, the requestor has met the requirements of §134.600(b). The Division concludes that the respondent's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 Texas Register 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. 28 Texas Administrative Code §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed or after January 1, 2003, requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." The Division notes that the requestor listed disputed dates of service 9/29/2003, 9/30/2003 and 10/30/2003 on the Table of Disputed Services. Review of the requestor's bill indicates that the services in dispute were performed on 10/29/2003 only. The Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 Texas Administrative Code §133.307(e)(2)(C).
6. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report and progress report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
7. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor did not submit a position statement for consideration in this dispute.
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor submitted additional documentation in response to the Commissioner's Bulletin #B-009-07 Medical Fee Dispute Resolution Update to support that on average, the hospital received 51% to 96% of billed charges for laminotomy with decompression performed during this time period. However, review of the submitted data finds that the additional information does not support the reimbursement amount sought by the requestor.
   - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former Acute Care Inpatient Hospital Fee Guideline, which states at 22 Texas Register 6276 that:

     > "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

     Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under

Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 17, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.